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HMO'S, COST CONTAINMENT, AND EARLY OFFERS: NEW MALPRACTICE THREATS AND A PROPOSED REFORM

Jeffrey O'Connell* and James F. Neale**

Wall Street Journal columnist George Anders devotes the first thirteen pages of his book, *Health Against Wealth: HMOs and the Breakdown of Medical Trust*,¹ to a Georgia couple directed over a "hotline"² by a cost-conscious health maintenance organization ("HMO")³ to drive their ailing infant forty-two miles past numerous other hospitals to one at which the HMO received a ten percent discount.⁴ Because the child's meningococemia⁵ was not immediately treated, physicians were forced to amputate the child's feet and hands. Anders alleges that the delay was unnecessary. A jury agreed, awarding the family a total of \$45.5 million.⁶

The American health care system is changing dramatically.⁷ Accompa-

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1. GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996).

2. Anders later notes that many health care providers refer to such utilization review as "1-800-DENIAL" services, *Id.* at 64, "telephone triage," *Id.* at 132, and "remote control medicine." *Id.*

3. An HMO is one example of a managed care organization and may be defined as "an organized system of health care delivery for both hospital and physician services in which care delivery and financing functions are offered by one organization." Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1 (1993).

4. ANDERS, *supra* note 1, at 10.

5. Meningococemia refers to the presence of bacteria in the blood that causes meningitis or the inflammation of membranes surrounding the brain and spinal cord. Once detected, meningococemia can be easily treated with antibiotics. But left unchecked, the condition may be fatal. J.E. SCHMIDT, M.D., 4 ATTORNEY'S DICTIONARY OF MEDICINE AND WORD FINDER 120-22 (1997).

6. The family accepted a significantly reduced amount when the HMO forfeited its right to appeal. ANDERS, *supra* note 1, at 11.

7. For a thorough historical review of the American health care delivery system, see John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions*, 3 CONN. INS. L. J. 1 (1996).

nying these changes are new threats of malpractice. By definition, managed care organizations ("MCOs")⁸ impose cost-containment policies upon the patients and providers with whom they contract. As Anders correctly illustrates, these measures often have medical implications that could give rise to malpractice claims.⁹ In addition to traditional medical malpractice risks, HMO patients now face the risk of injury resulting from financially motivated denial of treatment.

Generally speaking, the present malpractice system inadequately compensates victims and fails to deter negligent providers.¹⁰ The system also imposes tremendous transaction costs upon all concerned.¹¹ The new risks attendant to cost-containment policies reinvigorate the need for critical examination of our present malpractice system and its possible alternatives. This in turn provides an opportunity for legal scholars and reformers to inquire whether an already distressed tort system should bear the additional burden of resolving a rush of new malpractice claims against HMOs or whether an alternative might better serve society. In reviewing Anders' book, this Article details the new malpractice risks, critiques the tort system's ability to address satisfactorily medical malpractice claims against HMOs, and suggests that an "early offer" compensation scheme represents a much-needed reform for HMOs as well as traditional malpractice claims.

I. THE NEW MALPRACTICE THREAT: A REVIEW OF *Health Against Wealth*

In *Health Against Wealth*, Anders passionately, if not altogether convincingly, alleges that for-profit HMOs systematically compromise mem-

8. Managed care is a comprehensive term "used to describe a variety of mechanisms [including HMOs], ranging from reduced-price purchasing agreements with health care providers to pre-authorization of facility admissions or surgical procedures." Carla Jensen Hamborg, *Medical Utilization Review: The New Frontier for Medical Malpractice Claims*, 41 *DRAKE L. REV.* 113, 113 (1992). For a description of various MCOs, see Peter T. Kilborn, *Workers Getting Greater Freedom in Health Plans*, *N.Y. TIMES*, Aug. 17, 1997, at A1; see also VERGIL N. SLEE & DEBORAH ASLEE, *HEALTH CARE TERMS* (2nd ed., 1991).

9. See also Thomas Bodenheimer, *The HMO Backlash—Righteous or Reactionary*, 335 *NEW ENG. J. MED.* 1601 (1996) (describing criticism of HMOs). The first reported case of a patient alleging negligent utilization review was *Wickline v. State*, 228 *Cal. Rptr.* 661 (Ct.App. 1986), *appeal dismissed*, 741 P.2d 613 (1987). However, HMOs, unlike fee-for-service providers, are forced to internalize any future financial effects of malpractice their patients might suffer. One could plausibly argue that this serves as an additional incentive for HMOs to minimize any occurrences of medical malpractice.

10. PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* (1991).

11. *Id.*

bers' health to maximize profits. He argues that "medical commissars"¹² and "overseers who restrain what doctors can do"¹³ reduce costs by ruthlessly enforcing medical utilization review¹⁴ and purchasing agreements.¹⁵ Anders alleges that cost-containment policies have greatly restricted providers' discretion, thereby undermining "compassion and the best aspects of American medical care . . . in favor of a grim medical assembly line that bounces patients along without any sensitivity to their unique concerns."¹⁶

The villains of Anders' work are HMO executives whom the author describes as "barons of austerity"¹⁷ and "doctors in pinstripes . . . [with] a raw hunger for wealth."¹⁸ Anders alleges that they "swagger in their new prosperity . . . pamper[ing] themselves with corporate jets, sleek black limousines, and private chauffeurs."¹⁹ He notes that their corporations occupy "splendid suburban headquarters with landscaped grounds, waterfalls, and big, bright work areas . . . [as] lavish as those of comparable Fortune 500 companies that [make] . . . cigarettes, missiles, or motorcycles."²⁰

Subsidizing this unabashed greed is less costly and, Anders asserts, less effective than medical treatment of individual patients. But beyond a very few statistics,²¹ Anders presents little empirical data.²² Most of his

12. ANDERS, *supra* note 1, at 13.

13. *Id.* at x.

14. Medical utilization review is a "comprehensive evaluation of the efficiency, appropriateness, and medical necessity of health care." It may occur before, during, or after the provision of health care. Hamborg, *supra* note 8, at 116. For a critical opinion of the now-prevalent practice, see Jonathon Sharfstein, *Who will Review the Managed Care Reviewers?*, N.Y. TIMES, May 29, 1997, at A20.

15. Purchasing agreements refer to contracts between the HMO and the health care provider that impose mutual financial incentives. Normally, the HMO guarantees that its members will seek treatment from member providers in exchange for discounts for that treatment. Randall, *supra* note 3, at 4.

16. ANDERS, *supra* note 1, at 42.

17. *Id.* at 55.

18. *Id.* at 67.

19. *Id.* at 57.

20. *Id.* at 63.

21. Anders notes that the for-profit U.S. HealthCare spends only 70 percent of its gross receipts on medical care while a non-profit like Kaiser Permanente typically spends 90-95 percent of its revenues on medical care. *Id.* at 62. He also cites surveys alleging that 20 percent of HMO members have been denied coverage for emergency treatment and that 21 percent of HMO members in poor health were denied access to specialists within the past year, compared to only 15 percent of comparable fee-for-service patients. *Id.* at 79. Anders also provides empirical data assessing cardiac surgery to support his assertion that HMOs consistently contract for financial savings over medical efficiency, even when

evidence, though emotionally compelling, is anecdotal. While academics may criticize the work for lacking a more quantitative foundation,²³ Anders' novelistic approach is quite readable and is likely to arouse many HMO patients, providers, and others.

Following the story of the Georgia child injured because his HMO failed to deviate from its purchase agreement, Anders introduces his readers to a series of other patients similarly injured by their HMOs' cost-containment policies. Among the more notable is a patient suffering from a blood-plasma disorder whose new HMO routinely denied him access to the specialists who had previously treated him. A New York jury awarded him more than \$1 million.²⁴ Anders similarly recounts the stories of several HMO members suffering breast cancer who were denied coverage for bone marrow transplants because their HMOs considered the treatment "experimental." A California jury awarded the estate of one of the women \$89.1 million.²⁵

These cases are compelling and well-told. However, they are an insufficient foundation upon which to universally condemn cost-containment policies. In some cases, such policies admittedly prompt providers to eliminate tests and procedures that may be desirable, or even necessary. But Mr. Anders' grim picture conveys only part of the story. Cost-containment policies, at least arguably, have been quite successful in many respects.²⁶ In 1996, after the wide-scale adoption of managed care, em-

the less expensive center might have twice the mortality rate of its competitor. *Id.* at 93, 99-103.

22. Most empirical studies contradict Anders' assertions, indicating that HMO-provided treatment is less costly and no less medically sound than treatment delivered under the fee-for-service system. Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 593 (1997) (citing Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1517 (1994)).

23. See, e.g., Robert J. Samuelson, *Mismanaged Care*, N.Y. TIMES, Nov. 24, 1996, at 13 ("mass clinical studies don't yet show that managed care has systematically eroded quality"); see also Peter Phipps, *Health Care Anecdotes Are Everywhere, But How About Some Data?* PROVIDENCE J. BULL., Oct. 27, 1996, at F1.

24. ANDERS, *supra* note 1, at 80.

25. The parties agreed to a much lower amount when the HMO forfeited its right to appeal. In this trial, a former employee of the HMO testified against her company after it initially denied her coverage for similar treatment. *Id.* at 115. Following the case, the California legislature required HMOs to cover bone marrow transplants in all basic health plans. *Id.* at 129; see also CAL. WELF. & INST. CODE § 14133.8 (West 1991).

26. See, e.g., David Wessel, *Health-Cost Trims Hold Inflation Down*, WALL ST. J., June 30, 1997, at A1; but see David S. Hilzenrath, *What's Left to Squeeze?*, WASH. POST, July 6, 1997, at H1 (arguing that HMO cost-containment measures now approach the point of diminishing returns).

ployers' health care premiums rose less than 1 percent, whereas in 1991, prior to the adoption of managed care, the increase had been 11.5 percent.²⁷ In 1996, the average managed care plan cost employers \$3,305 per employee compared to an average fee-for-service plan cost to employers of \$3,739 per employee.²⁸ HMOs would seem a justified and, indeed, predictable response to the grossly exorbitant fee-for-service²⁹ system that they replaced. Under the fee-for-service system, providers had every incentive to engage in, and insurers had little ability to contest, medically unnecessary care.³⁰ Managed care represents a response to the moral hazard that necessarily accompanies any third-party payer system.³¹ In denying coverage, HMOs effectively shift the financial burden of unnecessary treatment to patients and health care providers.³² Because few patients have the ability to incur these costs individually, providers must either refrain from the treatment or provide it at their own expense.

Anders is certainly correct in noting that this shift creates the potential for injury caused by the improper denial of coverage for treatment. But he fails sufficiently to balance the risk of these injuries against the many

27. Samuelson, *supra* note 23, at 13.

28. Mike McNamee, *Health Care Inflation, It's Baaack!*, BUS. WK., Mar. 17, 1997, at 28.

29. Under a fee-for-service system, the insurer compensated the provider for every instance of treatment an insured patient received. Thus, the patient receiving more treatment offered the provider greater financial gains. For the view that providers' opposition to HMOs is principally motivated by financial reasons, see Duncan Moore, *Doctors Against Profits (Except Their Own)*, WALL ST. J., Dec. 17, 1997, at A22. Even one commentator critical of managed care euphemistically refers to the "fee-for-service" system as the "free-lunch" system. Randall, *supra* note 3, at 86 n.45. Under a managed care system, in contrast, providers are often paid a "capitation fee" based on the number of patients who subscribe to their services or a predetermined payment based on the diagnosed condition, rather than payments for individual treatments actually rendered. Thus, the patient receiving less treatment offers the provider greater financial gains and, arguably at least, a greater incentive to provide preventive care to keep the patient group healthier. See *infra* note 35 and accompanying text.

30. Incentives under such a system are commonly referred to as presenting a "moral hazard," encouraging the parties to engage in treatment that neither the provider nor the patient, absent guaranteed reimbursement from a third party, would desire. Randall, *supra* note 3, at 86 n.46 (citing Mark A. Hall & Ira Mark Ellman, *HEALTH CARE LAW AND ETHICS* 8 (1990)).

31. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982). For a much more extensive discussion of alleged waste and fraud in Medicare billing and payment (normally under modified fee-for-service, not HMOs), see Robert Pear, *Audit of Medicare Finds \$23 Billion in Overpayments*, N.Y. TIMES, July 17, 1997, at A1.

32. Randall, *supra* note 3, at 30.

benefits achieved by HMOs. HMOs have reduced medical costs³³ by eliminating automatic payment for unnecessary procedures,³⁴ discouraging over-utilization of emergency rooms,³⁵ and imposing administrative discipline on "M.D.-ities"³⁶ that were previously beyond reproach. Proponents of managed care argue that national standards have improved the quality of care patients receive and that the financial incentives of HMOs have increased the prevalence of preventative medicine.³⁷ It is likely that cost-containment measures will continue at the behest of employers, because health care expenses now represent the largest single component cost of American manufacturing.³⁸ Because of the successes employers perceive, and an apparent lack of other viable alternatives,³⁹

33. One study of 222 employers noted that utilization review programs reduced cost by an average of 8.3 percent. Glenn Ruffenback, *Employers Can Cut Health Care Costs with "Utilization Review," Study Finds*, WALL ST. J., May 19, 1988, at A38. Although it is commonly asserted that HMOs have already achieved most of the sayings they are capable of, see, e.g., Spencer Rich, *Open Season: Health-Care Premiums are Going Up*, WASH. POST, Nov. 11, 1997, at 16, of a special "Health" supplement (see also Hilzenrath, *supra* note 26, at H1). For a contrary view that they will continue to decrease health care costs by discouraging technical innovation in health care delivery, see David Vessel, *Health Cost Trims Hold Inflation Down*, WALL ST. J., June 30, 1997, at A1. Of course such a role could lead to its own excitement of malpractice claims.

34. Randall, *supra* note 3, at 86, n.107, (stating a 1988 study concluded that nearly 10 percent of Medicare admissions were not medically justifiable).

35. Some HMOs boast of reducing emergency room treatment by as much as 40 percent. See generally Laurence C. Baker & Linda Schuurman Baker, *Excess Cost of Emergency Department Visits for Nonurgent Care*, 13 HEALTH AFFAIRS 162, 170 (Winter, 1994) (estimating that the nationwide cost of excess emergency treatment was between five and seven billion dollars in 1993).

36. ANDERS, *supra* note 1, at 23.

37. See, e.g., Peter T. Kilborn, *Doctors Organize to Fight Corporate Intrusion*, N.Y. TIMES, July 1, 1997, at A12; see also Lloyd M. Krieger, *Doctors and Divided Loyalties*, WASH. POST, Jan. 22, 1998, at A21 (lauding managed care for promulgating uniform standards and systemic data).

38. Chris Snowbeck, *Health Care Professionals Learning Business Aspect of Their Field*, CHARLOTTESVILLE DAILY PROGRESS, Apr. 13, 1997, at A1.

39. Though some commentators herald Medical Savings Accounts ("MSAs") as a viable alternative both politically and economically, See, e.g., Bruce A. Barron, *The Price of Managed Care*, 103 COMMENTARY 49, 52 (1997); see, e.g., Edward M. Kennedy & Richard A. Gephardt, *Messing With Medicare*, WASH. POST, June 26, 1997, at A19; see also John Judis, *Careless*, THE NEW REPUBLIC, July 28, 1997, at 14; see generally, Kilborn, *supra* note 37, at A12 (discussing providers and medical school professors thoughts on alternatives to HMOs). For an indication of the frustration of HMOs in attempts to further reduce health care costs (quite apart from mandates to increase benefits—see *infra* notes 144-52) consider the following:

In some cities, hard-bargaining health plans are paying a price for creating a sense of panic among rival hospitals and inspiring them to consolidate. Where HMOs and Preferred Provider Organizations once held the upper hand in negotiations,

managed care seems here to stay. It has, as Anders notes, become "the de facto national health policy of the United States."⁴⁰

Americans place three competing demands on their health care system. They seek to expand coverage and to control costs, to preserve the individual autonomy and the quality of care that characterized the fee-for-service system.⁴¹ Unfortunately, the three goals directly conflict with one another. Any substantial effort to control costs threatens to reduce access, autonomy, or quality of care. As one editorial stated, "[a]t some point a cap on price becomes a cap on care."⁴² Conversely, any substantial effort to increase access, autonomy, or quality of care threatens to raise health care costs. However, Anders never explicitly recognizes, much less reconciles, this obvious tension. His work vividly and capably illustrates the possible adverse effects of allocating care with limited resources, but it provides little practical assistance for making those allocations, or for assessing the social utility of cost-containment measures.

After discounting market,⁴³ regulatory,⁴⁴ and political⁴⁵ safeguards,

the merged hospitals now wield increased market clout, making it easier for them to raise prices or resist price cuts, health care analysts and executives say.

David S. Hilzenrath, *Nation's Hospitals the Picture of Health*, WASH. POST, Feb. 7, 1998, at H1.

40. ANDERS, *supra* note 1, at 244.

41. Samuelson, *supra* note 23, at 13.

42. *Health Care Heavies*, WASH. POST, Feb. 28, 1997, at A20. See also George Anders & Ron Winslow, *HMOs Woes Reflect Conflicting Demands of American Public*, WALL ST. J., Dec. 22, 1997, at A1.

43. Anders doubts that market safeguards offer any protection for HMO members. Patients have little opportunity to bargain with HMOs because they have so much invested in their jobs and there is no real exit option. See generally ANDERS, *supra* note 1, at 246-62.

44. *Id.* at 230. (stating the internal review organization established by HMOs in the 1970s approved every managed care plan it reviewed) ANDERS, *supra* note 1, at 230. (arguing that physician members are ineffective critics because HMOs have employed legal and financial incentives (so-called "gag rules") to keep their member providers from complaining about poor quality either to patients or press). *Id.* at 80. While state regulators purport to provide at least minimal protection, Anders characterizes them as inept, compromised, and understaffed. California, for instance, assigned only two full-time regulators to review all HMO member complaints within the state. *Id.* at 231 (citing Michael A. Hiltzik & David R. Olmos, *The Health Care Revolution, Remaking Medicine in California*, L.A. TIMES, Aug. 27, 1995, at A1).

45. ANDERS, *supra* note 1, at 212 (arguing politicians are likely to focus only on vote-winning and "superficial" strategies—guaranteeing 48-hour hospital stays instead of less expensive "drive-through deliveries"). They are also arguably unlikely to impose wholesale reforms upon the industry because they are dependent upon managed care to reduce cost increases in entitlement programs like Medicare and Medicaid. Cathy L. Burgess, *Comment, Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review*, 4 J. CONTEMP. HEALTH L. & POL'Y, 275, 291-92 (1988); see also, *infra* notes 144-54 and accompanying text.

Anders makes ten specific recommendations designed to "bring better human judgment into the system."⁴⁶ Here, perhaps, his work is least persuasive of all. Following thirteen chapters of vehement criticism, his "solutions" often amount to little more than a dignified surrender. He urges regulators to "patrol the ways that HMOs pay doctors;"⁴⁷ doctors to "establish better report cards on the quality of health plans;"⁴⁸ and members to "know how to file effective complaints."⁴⁹ But finally—and most crucially—Anders argues that abusive cost-containment policies should be subjected to "the spotlight" of tort liability.⁵⁰

II. THE "SPOTLIGHT" OF TORT LIABILITY

Ideally, civil liability should fully compensate injured patients and adequately deter negligent providers without affecting the behavior of non-negligent providers. But contrary to Anders' suggestion regarding the curative effects of our tort system, evidence strongly suggests that medical malpractice tort law is grossly ineffective in these regards. Research suggests that few victims of medical negligence file a lawsuit, and that the substantial majority of malpractice suits actually filed have no basis in medical fact.⁵¹ The most widely cited source from a Harvard interdisciplinary study suggests that only one in eight negligently injured plaintiffs files a tort claim, and that only one in sixteen is eventually compensated.⁵² One source reports that one half of plaintiffs' attorneys saw little or no evidence of malpractice in more than fifty percent of their cases.⁵³ These figures strongly suggest that our fault-based, adversarial tort system fails to compensate deserving injured patients, fails to deter negligent providers, and adversely affects non-negligent providers.

In sum, our current tort system is ill-equipped to resolve either tradi-

46. ANDERS, *supra* note 1, at 246-62.

47. *Id.* at 251.

48. *Id.* at 258.

49. *Id.* at 256.

50. *Id.*

51. *Early Offers Could Cut Malpractice Suits, Speed Payouts to Injured, Analyst Says*, BUREAU OF NATIONAL AFFAIRS, DAILY REPORT FOR EXECUTIVES, Nov. 25, 1996, at A-25.

52. *Harvard Medical Malpractice Study: Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, A Report by the Harvard Medical Practice Study to the State of New York, Harvard College (1990).

53. Michael B. Van Scoy-Mosher, *An Rx for the Malpractice Explosion*, L.A. TIMES, June 28, 1983, at 4 (reviewing D. FLASTER, *MALPRACTICE: A GUIDE TO THE LEGAL RIGHTS OF PATIENTS AND DOCTORS* (1983)).

tional medical malpractice claims or those filed against HMOs.⁵⁴ Part III of this Article breaks the problem down into three parts. First, it describes the tort system's compensatory shortcomings. Next, the section details the tort system's deterrent shortcomings. Then it reveals the enormous transaction costs imposed by the tort system. The final section of Part III illustrates the reasons that these inadequacies are particularly acute in malpractice claims against HMOs.

A. Compensation

Harvard Law School Professor Paul Weiler, a senior author of the Harvard study just mentioned, lamented that:

[v]iewed as a form of insurance, the malpractice regime has major flaws. . . . [t]ort benefits are doled out in a rather arbitrary manner to some—but not most—deserving victims, and also to those . . . who are not even 'deserving' under tort law's fault-based frame of reference.⁵⁵

Others have similarly described the negligently-injured plaintiff's chance of recovery as speculative and "lottery-like."⁵⁶ One recent study published in the *New England Journal of Medicine* indicates that a plaintiff's degree of disability, rather than a provider's negligence, is most significantly statistically correlated with tort recovery.⁵⁷ Such evidence understandably prompts criticism of the tiresome, expensive, and punishing show of casting blame when the assignment of "fault" appears to be largely a charade, irrelevant to litigation results.

Even the "fortunate" few who are fully compensated are not likely to be adequately remunerated for their full economic losses: up to forty percent of any plaintiff's award is immediately diverted to attorney's fees, regardless of the attorney's investment in or the complexity of the case.⁵⁸ Additionally, the average medical malpractice tort claim takes over eight-

54. Despite the criticism offered herein, many still support the tort system. See, e.g., Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996).

55. Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 915 (1993).

56. David S. Starr, *The No-Fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence, and Viability Aspects of a Patient Compensation Scheme*, 20 TEX. TECH L. REV. 803, 806 (1989).

57. Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1966 (1996).

58. Starr, *supra* note 56, at 806-07 n.23; see also Murray L. Schwartz & Daniel J.B. Mitchell, *An Economic Analysis of the Contingent Fee in Personal Litigation*, 22 STAN. L. REV. 1125 (1970) (noting that the contingent fee represents the greatest single cost for the

een months to settle or adjudicate⁵⁹—a time during which injured plaintiffs' financial needs may be most acute, but during which any pecuniary recovery under tort law is denied.⁶⁰

B. Deterrence

In addition to compensating malpractice victims in an unpredictable and inadequate manner, the tort system inefficiently deters providers. A punitive system must accurately and fairly assess liability in order to deter potential wrongdoers without affecting the behavior of non-negligent providers. In contrast to this ideal, Troyen Brennan, a lawyer and a professor at both Harvard's Medical and Law Schools, compared the tort system to "giving tickets to a lot of people who weren't speeding, but letting a lot of speeders go by."⁶¹ Because the tort system fails to assess liability accurately, it over- and under-deters providers, prompting many to question the system's efficacy in deterring negligent care.⁶²

The lack of claims in tort law results in substantial under-deterrence. In other words, numerous false negatives, or instances that warrant liability but none is found, occur. Problems of under-deterrence are compounded by two other factors. First, even the most deserving tort judgment is substantially delayed, thereby attenuating the chronological connection between the negligent act and the eventual "punishment."⁶³ Second, the deterrent effect on most tort defendants is decreased because almost all are indemnified by insurers.⁶⁴ Malpractice insurance is priced by specialty and location, rather than by individual merit rating, thereby

plaintiff). Of course, the defendant, win or lose, is forced to expend substantial resources on attorneys' fees.

59. S.Y. Tan, *Comment, The Medical Malpractice Crisis: Will No-Fault Cure the Disease?* 9 U. HAW. L. REV. 241, 243 n.13 (1987) (noting also that 10 percent of medical malpractice cases remain open for over six years).

60. *But see* Section II, Subsection D *infra* (asserting that the HMO-member plaintiff may be in a relatively favorable situation in this regard).

61. JEFFREY O'CONNELL & C. BRIAN KELLY, *THE BLAME GAME, INJURIES, INSURANCE AND INJUSTICE* 131 (1987).

62. Susan Okie, *What Wins Malpractice Cases?*, WASH. POST, Jan. 14, 1997, at Z07 (quoting Troyen Brennan, *supra* note 57, "I think there's very little evidence of the deterrent effect of tort litigation").

63. Arthur B. Laby & W. Hardy Calcott, *Patterns of S.E.C. Enforcement under the 1990 Remedies Act: Civil Money Penalties*, 58 ALB. L. REV. 5, 52 (1994) (applying the same argument in securities regulation).

64. Josephine Y. King, *No Fault Compensation for Medical Injuries*, 8 J. CONTEMP. HEALTH L. & POL'Y 227, 227 (1992) (noting that "protection [from liability] through indemnification has stunted, blunted, or obliterated a fear" of liability); *see also* Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about*

muting the financial deterrence normally combatting an insured's negligent behavior.⁶⁵ As HMOs are exposed to more liability, they similarly insulate themselves with unprecedented levels of liability insurance.⁶⁶

Evidence of tort law's under-deterrence is perhaps most convincingly offered by courts themselves. In refusing to impose liability upon an HMO for the negligent denial of care, a federal appeals court noted that liability would have only a mild "salutary effect of deterring poor-quality medical decisions."⁶⁷

To the extent the tort system does deter, it may well over-deter non-negligent providers. Studies suggest that "pain and suffering" damages are determined as much by bias and whim as by evidence or analysis.⁶⁸ Because potential malpractice defendants perceive themselves vulnerable to the arbitrary imposition of "irrational [and] illogical"⁶⁹ pain and suffering damages, regardless of their own negligence, they are arguably over-deterred. Such over-deterrence is commonly referred to as "defensive medicine."⁷⁰ In an effort to insulate themselves from even a remote possibility of tort liability, providers may rely upon unnecessary tests and

the Deterrent Effect of Tort Liability, 35 SYR. L. REV. 939, 954 (1984) (stating that insurance "eviscerates the economic sanction that tort liability presents against medical negligence").

65. Bell, *supra* note 64, at 955 (asserting that "a doctor must be aware that so long as he purchases malpractice insurance, he need not worry about the economic consequences of his negligent medical behavior"); see also Wyckoff, *The Effects of a Malpractice Suit Upon Physicians in Connecticut*, 176 JAMA 1096, 1098-99 (1961) (reporting that of 58 physicians sued in Connecticut, 52 said that the suit did not affect their practice, one said that it negatively affected her practice, and five said that it positively affected their practice).

66. *Uneasy HMOs Boost Liability Limits*, 22 MED. LIABILITY MONITOR 4 (1997).

67. *Corcoran v. United Health Care*, 965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (1992). Note that the judiciary similarly discounts tort law's deterrent effect in exempting itself from tort liability. See, e.g., *Stump v. Sparkman*, 435 U.S. 349 (1978) (providing judicial immunity from civil liability). See also Jeffrey O'Connell & Ralph M. Muoio, *The Beam in Thine Eye*, 1997 U. ILL. L. REV. 491 (1997).

68. See, e.g., Richard Morin, *Beauty and the Beast in the Courtroom*, WASH. POST, Nov. 30, 1997, at C5 (describing study which suggests the parties' physical attractiveness, race, and gender helps to determine civil and criminal cases). See also Henson Moore & Jeffrey O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267, 1268 (1984) (arguing that female plaintiffs receive more in pain and suffering damages than do males, and older plaintiffs receive more than younger plaintiffs).

69. King, *supra* note 64, at 235.

70. See *Study Finds Direct Tort Reforms Could Cut Defensive Medicine, Pare Medical Costs*, MED. LIABILITY MONITOR, Feb. 21, 1997, at 6 (citing a study by David Kessler and Mark McClellan of Stanford University and the National Bureau of Economic Research, which estimated that tort reforms might lead to savings of \$50 billion per year in defensive medicine costs without adversely affecting the quality of health care).

procedures to preclude any possibility of a "false positive," a finding of liability where none is warranted. In other words, the uncertainty of tort law prompts providers routinely to provide treatment for legal rather than medical reasons.⁷¹ A recent study focusing on defensive medicine co-authored by a physician and an economist suggests that nationwide tort reform could produce savings of \$50 billion a year without serious adverse health-care consequences.⁷² In addition to such "positive" costs of defensive medicine, over-deterrence might also result in "negative" costs. Examples include providers' unwillingness to perform a difficult or experimental procedure,⁷³ or even their early retirement.⁷⁴

C. Unnecessarily High Transaction Costs

In addition to inadequate compensation and inefficient deterrence, the tort system imposes enormous transaction costs upon all parties. These costs are perhaps nowhere more evident than in medical malpractice cases. Harvard's Troyen Brennan estimates that sixty cents of every dollar paid in malpractice insurance premiums is expended on "administrative costs of malpractice suits: lawyers' fees, court fees, medical experts, and other associated costs."⁷⁵ Other studies suggest that the figure may be as high as seventy-two cents.⁷⁶ In addition to these financial costs, the psychological costs tort litigation imposes upon plaintiffs,⁷⁷ as well as providers,⁷⁸ are well documented. Neuropsychiatrist Lester Keiser reports that "the nervous strain experienced by a [negligence] . . . victim is

71. Armand Leone, Jr., *As Health Care Enterprise Liability Expands . . . Is ADR the RX for Malpractice?*, 49 DISP. RESOL. J. 7, 10 (1994); see also Laurence R. Tancredi, *Designing a No-Fault Alternative*, 49 J. L. & CONTEMP. PROB. 277, 279 (1986) (citing *AMA Study Reports Sharp Increase in Malpractice Claims Against Physicians*, Med. Liab. Advis. Service, Jan. 1980, at 16); see also Brinkley, *AMA Study Finds Big Rise for Claims in Malpractice*, N.Y. TIMES, Jan. 17, 1985, at A1.

72. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, Q. J. OF ECON., May 1996, at 353.

73. See, e.g., Jennifer O'Sullivan, *Medical Malpractice*, CRS Report for Congress, Jan. 28, 1997, at 5 (citing an American College of Obstetrician and Gynecologists ("ACOG") survey which reported that one quarter of members decreased high-risk obstetrical care because of fear of tort liability).

74. Moore & O'Connell, *supra* note 68, at 1270; see also O'Sullivan, *supra* note 73, at 5 (citing ACOG study indicating that 12.3 percent of members gave up obstetrics in 1992 because of fear of tort liability); Roger Rosenblatt, *Why do Physicians Stop Practicing Obstetrics?: The Impact of Malpractice Claims*, 76 OBSTETRICS AND GYNECOLOGY 245 (1990).

75. Okie, *supra* note 62, at Z07.

76. O'CONNELL & KELLY, *supra* note 61, at 127.

77. Starr, *supra* note 56, at 806-07 n.23.

78. Leone, *supra* note 71, at 10 n.18.

often intensified in the ensuing wrangles with claim adjusters and lawyers [Some plaintiffs] become so absorbed in nursing their symptoms and pressing their claims that they completely alter their lives."⁷⁹

It is often extremely difficult for any expert to engage in post-procedure analysis of complex medical treatment and to identify and isolate an allegedly negligent act. It is arguably even more difficult for laypersons to reconcile competing experts' opinions regarding these complexities.⁸⁰ Yet, this is exactly the task our current tort system delegates to civil juries. While it may be within the ken of a jury to determine the negligence of an automobile driver (a determination that at least requires jurors to draw from their own common and routine experience), asking the jury to determine the competence and consequences of complex medical procedures is an infinitely greater task. Because these matters are so complex and unpredictable, even skilled and experienced plaintiffs' attorneys litigating a particular case are rarely entirely confident of the validity or value of their clients' claims.⁸¹ (How else could a plaintiff's attorney justify charging a contingent fee of a third or more?)

In an action against an HMO for negligent cost containment, the jury's task might be even more difficult than in a typical malpractice case, in that the jury is required to determine the complexities of advanced and often experimental medical treatment and at the same time resolve complicated financial and ethical dilemmas. Only after determining the savings produced by a particular cost-containment measure would the jury be in an appropriate position to determine whether the injury in the instant case was the result of improper care—assuming we can expect jurors to be this objective about such emotional matters.⁸²

These complexities impose heavy transaction costs upon all parties to medical malpractice litigation. The billions of dollars expended on malpractice insurance premiums each year do not usually include the increasing resort to self insurance by large health care providers.⁸³ High-risk specialists in states like New York and Florida pay annual malpractice

79. O'CONNELL & KELLY, *supra* note 61, at 133-34.

80. *But see generally*, Neil Vidmar, *Empirical Evidence on the Deep Pocket Hypothesis: Jury Awards For Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217 (1993). For a somewhat critical review of Vidmar's book, see Jeffrey O'Connell & Christopher Pohl, forthcoming in J.L. & HEALTH.

81. O'CONNELL & KELLY, *supra* note 61, at 131-32.

82. Randall, *supra* note 3, at 34.

83. O'Sullivan, *supra* note 73, at 1.

premiums of up to \$200,000.⁸⁴ During one recent three-year period, annual medical malpractice premiums jumped 150 percent,⁸⁵ limiting providers' ability to effectively pass these costs on to the consuming public. Most malpractice litigation expenses are related to two identifiable issues: determining fault and ascertaining the amount of "pain and suffering" damages.⁸⁶ Though available elsewhere, exorbitant pain and suffering damages may occur with greater frequency in malpractice suits (where they constitute about half of total damages⁸⁷) because malpractice jurors, contrary to jurors in an automobile case, will not expect to directly bear increased premiums as a result of their award to the plaintiff.⁸⁸ Researchers estimate the median jury award for a leg amputation in an automobile case to be \$199,999, while the same injury in a malpractice case warrants \$754,000.⁸⁹

D. HMO Malpractice and the Tort System's Inadequacies

Having detailed the general inadequacies of the tort system, this section of the Article illustrates the particular inadequacies of the tort system as evident in a malpractice claim against an HMO. Patient-employees allegedly injured by their HMO's negligence are likely guaranteed continuation of their medical coverage and of at least a portion of wages through employment-provided sick leave or disability insurance. Because the tort system is so expensive and cumbersome, or because sometimes even prevented by law from doing so, collateral sources of payment may not subrogate themselves to the plaintiff's malpractice claim. Claimants often, in other words, recover twice for incurring medical costs, once from the defendant and once from a collateral source.⁹⁰ Finally, the plaintiff's eventual recovery consists largely of "pain and suffering damages" which, data suggests, are often derived by multiplying economic, or empirically demonstrable, losses such as medical bills⁹¹ (for

84. Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499 (1991) (reviewing PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* (1991)).

85. 1 American Law Institute, Reporter's Study, Enterprise Responsibility for Personal Injury 3 (1991).

86. Joseph H. King, Jr., *The Exclusiveness of an Employee's Workers' Compensation Remedy Against his Employer*, 55 TENN. L. REV. 405, 412 (1988).

87. Vidmar, *supra* note 80, at 222.

88. Weiler, *supra* note 84, at 48.

89. Vidmar, *supra* note 80, at 219-20.

90. Kenneth Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 96 n.8 (1993).

91. Jeffrey O'Connell, *A Proposal to Abolish Defendants' Payments for Pain and Suf-*

which the plaintiff, to reiterate, is not directly responsible). Potential plaintiffs, therefore, are often insulated from any immediate financial need by health insurance and sick leave or disability insurance. This insulation is reinforced by an aggressive trial bar, which because of the contingent fee system, demands no upfront financial investment by a claimant to bring a medical malpractice suit. This system creates a manifest incentive to initiate and inflate medical malpractice claims, especially against an HMO, which by definition, only deals with patients for whom health care costs are already provided. "Nowhere in the world is there anything remotely comparable to the incentives to incur wasteful health care costs"⁹² as in America.

The present malpractice system, then, is inadequate in numerous ways. Given the opportunity, it is extremely doubtful that the majority of health care consumers, providers, or insurers would opt for the current system. Considering its inadequate compensation, deterrence, and high transaction costs, one might expect many to join Professor Patrick Atiyah in predicting that "in fifty years time people will look back with some horror on tort law as [having thrived] . . . too long."⁹³ As our health care delivery system undergoes the substantial change engendered by managed care, and as patients are arguably exposed to new threats of malpractice, it is in everyone's interest, except perhaps some lawyers, to seek a better system of compensation and deterrence.

III. THE LIKELIHOOD OF INCREASED MALPRACTICE LITIGATION AGAINST HMOs

Having acknowledged that Anders is correct in noting the potential for injury created by harmful cost-containment policies, and having illustrated tort law's deficiencies in traditional malpractice claims, Part III of this Article examines several factors that will substantially increase "new" medical malpractice claims—those against HMOs for the negligent denial

fering in Return for Payment of Claimants' Attorneys' Fees, 1981 U. ILL. L. REV. 333, 334-39 (1981); see also Peter Bell & Jeffrey O'Connell, Accidental Justice 191 (1997). Senator Mitch McConnell estimates that excess medical claims connected to lawsuits in which pain and suffering damages were at issue may total \$4 billion annually. 142 CONG. REC. S6082, 6097, 104th Cong., 2d Sess., June 11, 1996.

92. Jeffrey O'Connell, *Blending Reform of Tort Liability and Health Insurance: A Necessary Mix*, 79 CORNELL L. REV. 1303, 1309 (1994).

93. O'CONNELL & KELLY, *supra* note 61, at 133. But for a graphic portrayal of the increase in the number of those uninsured for health care from 1987 through 1996, see Milt Fruedenheim, *Progress on Health Care Costs, But Nagging Woes Persist*, N.Y. TIMES, Jan. 5, 1998, at C10.

of treatment. First, the growth of managed care would mean that more individuals gain coverage for medical treatment.⁹⁴ Empirical data demonstrates that increasing access to health care insurance in any form results not in fewer malpractice claims, but in commensurate, or even disproportionate, increases in tort litigation and costs.⁹⁵ As private and social loss-shifting insurance systems expand, tort liability, ironically enough, appears to consume increasingly large proportions of all available insurance funds.⁹⁶ Second, procedural barriers that historically have impeded plaintiffs injured by employment-provided health care plans are rapidly eroding.⁹⁷

Criticism of HMOs, both measured⁹⁸ and sensational, is certain to increase concern over the quality of HMO-delivered health care.⁹⁹ Recent allegations of fraudulent over-billing, both criminal¹⁰⁰ and otherwise,¹⁰¹ are nearly certain to increase public animosity toward HMOs. These unflattering portrayals are also likely to increase the frequency and severity of malpractice claims levied against HMOs.¹⁰² As these accounts proliferate, so will advertisements and other efforts from attorneys likely to benefit from malpractice claims.¹⁰³ In addition, the general dissatisfac-

94. See, e.g., R. Winslow, *HMOs are Expected to Deliver Strong Profit Growth*, WALL ST. J., Jan. 17, 1994, at B4; see also M. Mitka, *HMO Industry Stabilizes, Diversifies, Enrollment Up*, AM. MED. NEWS, July 19, 1993, at 7. Of course, negative portrayals and reasonable criticism of the managed care industry may temper such optimistic projections. See, e.g., Peter Passell, *In Medicine Government Rises Again*, N.Y. TIMES, Dec. 7, 1997, at 1.

95. See, e.g., O'Connell, *supra* note 92, at 1304-05.

96. *Id.*

97. See generally L. Frank Coan, Jr., Note, *You Can't Get There From Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Against HMOs*, 30 GA. L. REV. 1023 (1996).

98. See, e.g., *Consumers and Managed Care*, N.Y. TIMES, Feb. 9, 1997, at A14.

99. See Peter T. Kilborn, *Trend Toward Managed Care is Unpopular, Survey Finds*, N.Y. TIMES, Sept. 28, 1997, at 25 (describing poll that indicates "accelerating levels of dissatisfaction" from the previous year).

100. Kurt Eichenwald, *Columbia/HCA Inquiry is Said to Produce Evidence of Fraud*, N.Y. TIMES, July 18, 1997, at C1. Note though, that the greatest instances of fraud occurred not within managed care, but rather fee-for-service arrangements. See Kurt Eichenwald, *Hospital Chain Cheated U.S. on Expenses, Documents Show*, N.Y. TIMES, Dec. 18, 1997, at 1.

101. See Kurt Eichenwald, *Some in Congress Seek to Curb Inquiries into Fraudulent Billing By Teaching Hospitals*, N.Y. TIMES, July 3, 1997, at A14 (suggesting "clumsy government wording of the rules" is responsible for much of the problem).

102. BELL & O'CONNELL, *supra* note 91, at 192.

103. See, e.g., Sandra Torry, *As Managed-Care Plans Proliferate, So Do Lawsuits*, WASH. POST, Mar. 24, 1997, at E3 (reprinting Washington Post advertisement that asks in bold print "Are You an H.M.O. Victim?"); see also Sam Allis et al., *HMO Backlash*, TIME, Apr. 14, 1997, at 33 (reporting a radio advertisement that stated over the sound of a heart

tion of most health care providers with managed care¹⁰⁴—both those included and excluded from such plans—creates an “infinitely expanded bank of expert witnesses not only willing but eager to testify against” HMOs.¹⁰⁵ Consider, too, the plaintiff’s advantage in replacing the individual physician as the ultimate defendant with a faceless, deep-pocket, cost-cutting corporation.¹⁰⁶ It will likely be far easier to prove negligence in a corporate decision denying medical care than it currently is to prove that an individual physician’s actual treatment was, in fact, negligent.¹⁰⁷

Malpractice actions against HMOs are also likely to increase because procedural bars are slowly eroding. Historically, a plaintiff suing an employer-sponsored HMO faced a substantial impediment under the Employee Retirement and Income Security Act of 1974 (“ERISA”), a comprehensive federal act regulating employment-provided pension and benefits programs.¹⁰⁸ Since its inception, courts have more or less consistently ruled that ERISA preempted any state regulation of, or claim arising from, such a plan.¹⁰⁹

While state medical malpractice plaintiffs have a wide variety of potential tort remedies available, plaintiffs preempted by ERISA are limited to “carefully integrated civil enforcement provisions.”¹¹⁰ For instance, if an HMO were negligently to deny coverage for a \$100 blood test, and

monitor “this used to be the sound that mattered in determining your health care,” followed by the sound of a cash register ringing and the words “today, this is the sound that matters,” and then supplied a toll-free number to call “if you’ve been a victim of when profits come before patients”).

104. See generally *Survey Probes Doctors’ Views on Managed Care*, MED. LIABILITY MONITOR, Jan. 24, 1997, at 1 (reporting that 65 percent of California physicians viewed the impact of managed care on their practice as “negative,” and reporting the comments of one physician who stated that “managed care has cut my income, upped my paperwork, interfered with doctor-patient relationships, and demoralized my staff”).

105. BELL & O’CONNELL, *supra* note 91, at 192-93.

106. See Robert Pear, *HMOs Using Federal Law to Deflect Malpractice Suits*, N.Y. TIMES, Nov. 17, 1996, A24 (quoting HMO attorney Peter M. Roan, who noted that the physicians within HMOs were always potential defendants for malpractice claims but that plaintiffs want to include HMOs because they represent “another source of money”).

107. See generally BELL & O’CONNELL, *supra* note 91, at 193.

108. 29 U.S.C. §§ 1001-1461 (1988).

109. 29 U.S.C. § 1144(a) (1988) (ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (interpreting the preemption in “deliberately expansive” terms). See also *Shea v. Esenstein*, 107 F.3d 625 (8th Cir. 1997).

110. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (limiting recovery to contractual damages—including monetary losses, restitution and equitable relief, but not including compensatory or punitive damages); see also 29 U.S.C. § 1132(a)(2) (1988); and *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993).

\$100,000 in injuries resulted, the plaintiff's recovery is limited to \$100.¹¹¹ Federal courts have repeatedly and unapologetically noted that the plaintiff's inability to obtain satisfactory relief is irrelevant to their preemption analysis.¹¹² Courts, instead, note that liability would cause "catastrophic increases in the cost of employer-sponsored health care benefits, [and perhaps restrict access to these benefits] contrary to the intent of Congress."¹¹³

ERISA protects "fiduciaries" from negligence actions, but does not afford any protection to "providers."¹¹⁴ Generally, a fiduciary administers the health care plan, while a provider supplies the health care itself.¹¹⁵ Cost-containment measures, which determine the type and the amount of treatment that a patient will receive, blur the previously clear distinction between "fiduciaries" and "providers." If a court defines an HMO as a fiduciary, it effectively renders it immune from Anders' "spotlight of tort liability."¹¹⁶ Conversely, if an HMO is considered a provider, then it is exposed to more substantial state tort remedies. Predictably, Anders argues that HMOs are really "providers," not "fiduciaries," and that ERISA-provided immunity for HMOs was unintended and is unwarranted, leaving HMOs "essentially blameless for odious mistakes."¹¹⁷ Many traditional health care providers agree. Dr. Ted Lewers, a trustee of the American Medical Association, says that "if you're going to be involved in medical decisions . . . you should be held accountable."¹¹⁸

The preemption defense appears vulnerable.¹¹⁹ The Supreme Court

111. Stephanie Anderson Forest, *Revenge of the HMO Patients*, Bus. Wk., Mar. 17, 1997, at 30.

112. See, e.g., *Cannon v. Group Health Serv. of Okla.*, 77 F.3d 1270, 1274 (10th Cir. 1996) *cert. denied* __ U.S. __, 117 S.Ct. 66, 136 L.Ed.2d 27 (1996) (noting that the plaintiff's predicament was "not germane to preemption analysis"); see also *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

113. Pear, *supra* note 106, at A3.

114. See generally *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

115. 29 U.S.C. § 1002(21)(a) (1988); see also *Mertens*, 508 U.S. at 521.

116. ANDERS, *supra* note 1, at 256.

117. *Id.* at 255.

118. Forest, *supra* note 111, at 30.

119. See, e.g., Havighurst, *supra* note 22, at 611 (noting that: without legal accountability for quality, [HMOs] . . . may go far less than efficiency would dictate in integrating the delivery of care with its financing, leaving the health care revolution incomplete. In taking responsibility for (and seemingly profiting from) cost control while denying legal responsibility for quality, [HMOs] also do little to diminish public skepticism concerning their dedication to patient welfare).

See also *id.* at 639-40 (HMOs

must truly integrate their doctors into their health plans, taking real responsibility

invited an erosion of the preemption doctrine when it noted that "run-of-the-mill state law claims . . . or even torts committed by an ERISA plan" are not preempted.¹²⁰ Accepting the Court's apparent invitation, lower courts increasingly allow recovery against negligent HMOs.¹²¹ Courts may premise recovery upon an HMO's vicarious liability,¹²² "ostensible agency,"¹²³ "corporate negligence,"¹²⁴ and breach of contract claims.¹²⁵ Several federal appeals courts have agreed with Anders' reasoning and directly questioned the wisdom of any preemption that grants HMOs immunity.¹²⁶ Similarly, then Secretary of Labor Robert Reich has called federal preemption "absurd," and invited Congress to "clear the muddled waters."¹²⁷ At least three state legislatures have undertaken challenges to the preemption of state law claims.¹²⁸

for the services provided, and no longer [act] . . . merely as cost controllers. Once this crucial step is taken, liability law should have a more beneficial impact on the medical care industry, correcting incongruities inherited from the past and permitting the public to enjoy in relative safety the efficiencies of corporate medical care).

See also Deborah Gesensway, *The Struggle to Hold HMOs Liable*, AMERICAN COLLEGE OF PHYSICIANS OBSERVER, June 1997, at 1; see also David L. Coleman, *Will Health Plans Keep Their ERISA Shield?*, MANAGED CARE, May 1997, at 25.

120. *Mackey v. Lanier Collection Agency and Servs., Inc.*, 486 U.S. 825, 833 (1988).

121. See Jane Bryant Quinn, *Prognosis is Poor on Suits Against HMOs*, WASH. POST, June 1, 1997, at H2.

122. See, e.g., *Elsesser v. Hospital of the Phila. College of Osteopathic Med.*, 795 F.Supp. 142, 146-47 (E.D. Pa. 1992), *reconsidered*, 802 F.Supp. 966 (E.D. Pa. 1992).

123. See, e.g., *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983, 988-89 (E.D. Pa. 1990).

124. See, e.g., *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965).

125. See, e.g., *Dunn v. Praiss*, 656 A.2d 413 (N.J. 1985).

126. See, e.g., *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1338-39 (5th Cir. 1992), *cert denied*, 506 U.S. 1033 (1992) (acknowledging that "fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees").

127. See Pear, *supra* note 106, at A3.

128. See, e.g., Texas Civ. Prac. & Rem. §§ 88.002. Florida Governor Lawton Chiles vetoed similar legislation crafted by the Academy of Florida trial lawyers in 1996 on the grounds that health insurance rates would soar absent immunity. 1995 Fla. Laws ch.CS/hB1853. See Gady A. Epstein, *Chiles Weighs HMO Suit Bill*, TAMPA TRIB., May 24, 1996, at B1; see also Darryl Van Duch, *HMO Liability Laws May Hit Roadblocks*, NAT'L L.J., June 23, 1997, at B1 (describing legality of New York and Texas initiatives). Republican Congressman Charlie Norwood of Georgia reports that a majority of House members have co-sponsored a bill incorporated into federal legislation labeled the "Patients' Bill of Rights," which would strip HMOs of their ERISA protection. Gil Klein, *HMO Operations Face Cloudy Future*, CHARLOTTESVILLE DAILY PROGRESS, Dec. 14, 1997, at A2. Certainly attempts to amend ERISA so as to allow more common law malpractice suits against

Even if courts fail to directly challenge the ERISA preemption, they may grant state causes of action on another ground—the ERISA “savings clause.”¹²⁹ This clause gives the state exclusive control to regulate any aspect of the “business of insurance.”¹³⁰ Normally, any matter directly related to the explicit terms of an insurance contract is considered an aspect of the “business of insurance” and may be regulated or adjudicated by a state. As HMOs more explicitly incorporate cost-containment policies into health insurance plans, courts may be more likely to consider them an aspect of the “business of insurance,” thus satisfying ERISA’s savings clause, and thereby negating ERISA’s exemption from state law.¹³¹

The possible vulnerability of the ERISA preemption and widespread criticism of managed care leads to the specter of increased malpractice litigation against HMOs.¹³² Ironically, the American Medical Association, historically a consistently vocal critic of the tort system, is attacking the ERISA exemption provided to HMOs in an effort to deflect tort actions away from its member-physicians.¹³³ But because the current tort system so inadequately both compensates victims and deters providers, the addition of numerous and substantial malpractice claims against HMOs makes it even more necessary to examine alternatives to the current tort system rather than simply aiming a costly and arbitrary tort law toward new targets.¹³⁴ The remainder of this Article deals with several alternative regimes.

HMOs will face the same kind of vigorous opposition from employers and HMOs that face fundamental changes in other cost-containment features of HMOs.

129. 29 U.S.C. § 1144 (b)(2)(A) (1988).

130. See generally *Union Labor Life Ins. Co. v. Pireno*, 485 U.S. 119 (1982).

131. *Id.*

132. Pear, *supra* note 106, at A3 (citing a study by the physician-owned Medical Insurance Exchange of California that predicted “a flood of future litigation against managed care organizations, especially large ones with deep pockets” if the preemption were to erode). For a further discussion of the likelihood of malpractice claims against HMOs stemming from the changes in health care delivery wrought by HMOs, see BELL & O’CONNELL, *supra* note 91, at 191-94 (suggesting the greater ease of proving wrongful denial of treatment compared to surgical error, coupled with a new pool of plaintiffs’ expert witnesses in the form of physicians bitterly disenchanted with HMOs).

133. *AMA Says Dump ERISA Liability Shield*, MED. LIABILITY MONITOR, Apr. 19, 1997, at 3. For the view that erosion of HMO’s ERISA exemption would harm individual practitioners by providing HMOs even greater incentive to wrest control of medical decisions from providers (in an effort to avoid the liability erosion of ERISA would expose them to), see *What’s the Downside to Cutting ERISA Immunity?* MED. LIABILITY MONITOR, July 14, 1997, at 1.

134. *Id.*

IV. ALTERNATIVE REGIMES TO ADDRESS HMO MALPRACTICE

This portion of the Article is intended to demonstrate that "no-fault" malpractice insurance and legislative regulation of the managed care industry will not satisfactorily accommodate increased litigation against HMOs.

A. No-Fault Compensation

Under a "no-fault" compensation regime, defendants would provide claimants, regardless of fault, with compensation. No-fault schemes compensate victims more quickly and consistently than does the traditional tort system, and at a lower cost. No-fault regimes have worked well in other contexts—most notably automobile insurance and workers' compensation.¹³⁵ Several commentators have suggested that no-fault compensation be expanded to medical malpractice claims.¹³⁶ Both Virginia¹³⁷ and Florida¹³⁸ have instituted very limited "no-fault" regimes for claims arising from birth-induced neurological injuries. However, their effectiveness is much debated.¹³⁹ Even staunch advocates of no-fault compensation acknowledge that medical malpractice presents unique difficulties for a no-fault regime.¹⁴⁰

Comparing a person's physical health prior to an automobile or industrial accident, and determining which injuries were caused by that accident is relatively easy. Normally, all the accident victim's injuries are demonstrably caused by the workplace or auto accident itself. Medical malpractice victims are, however, in a very different situation. Prior to suffering any negligently inflicted injury, most suffer from a condition serious enough to warrant complicated treatment or invasive surgery. Many would suffer some lingering infirmity, regardless of whether their

135. See O'CONNELL & KELLY, *supra* note 61, at 131; and see generally Jeffrey O'Connell et al., *The Comparative Costs of Allowing Consumer Choice for Auto Insurance in All Fifty States*, 55 MD. L. REV. 160 (1996) (reporting favorable economic studies of no-fault automobile insurance plans).

136. See, e.g., Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 558 (1985); Tancredi, *supra* note 71, at 277.

137. See VA. CODE ANN. § 38.2-5000, *et seq.* (Michie Supp. 1990).

138. See FLA. STAT. § 766.301, *et seq.* (1997).

139. See Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451 (1988); see also Jeffrey O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 VA. L. REV. 1475 (1988); see also Mary A. Cavanaugh, *Note, Bad Cures for Bad Babies: Policy Challenges to the Statutory Removal of the Common Law Claim for Birth-Related Neurological Injuries*, 43 CASE W. L. REV. 1299 (1993).

140. Randall, *supra* note 3, at 78.

health care providers were negligent. Most complicated treatment (and all invasive surgery) necessarily produces subsequent "injuries," even absent negligence. It is therefore necessary to distinguish between the injuries caused by negligent treatment, and those caused by the "presenting complaint," which are simply unavoidably attendant to medical treatment.¹⁴¹ This problem of causation is an inhibiting factor in applying no-fault compensation plans to medical malpractice.¹⁴² Medical malpractice, therefore, presents unmanageably complex questions of causation to a system designed primarily for administrative simplicity, not analytical subtlety. In addition, because so few adverse consequences of medical treatment are now covered by medical malpractice litigation, a no-fault compensation scheme might well be prohibitively expensive.¹⁴³

B. Regulatory Legislation

In response to the kind of tales Anders tells, governmental regulation of HMOs is increasing.¹⁴⁴ Most legislative efforts so far are piecemeal reactions addressing one small, though objectionable, cost-containment measure.¹⁴⁵ While tempted to take aim at the "rougher edges" of man-

141. O'CONNELL & KELLY, *supra* note 61, at 128-29.

142. RICHARD EPSTEIN, *SIMPLE RULES FOR A COMPLEX WORLD* (1995). For an exhaustive study regarding the feasibility of no-fault insurance applicable to medical maloccurrences, see *Harvard Medical Malpractice Study*, *supra* note 52. This study seems to suggest that a true no-fault scheme may be feasible but further research is needed. For a skeptical view, see A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245 (1991). For a more optimistic view, see Paul Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355 (1992).

143. See *Harvard Medical Malpractice Study*, *supra* note 52; see also Localio, *supra* note 142, at 245.

144. For the view that governmental curbs on HMOs negatively affect the quality, access, and cost of health care, see RICHARD EPSTEIN, *MORTAL PERIL* (1997). For the view that the federal government should regulate emergency care provided by HMOs, see Diane E. Hoffmann, *Emergency Care and Managed Care—A Dangerous Combination*, 72 WASH. L. REV. 315 (1997). For an example of a troublesome cost-containment policy, see David S. Hilzenrath, *The Life-Savers' Dilemma*, WASH. POST, Jan. 17, 1998, at D1 (describing "medlining" riskier patients out of coverage). For a vigorous and rigorous defense of the corrective nature of HMOs in curbing the excesses of fee-for-service medicine, and an equally vigorous and rigorous attack on governmental attempts by legislation or regulation to curb the operations of HMOs, including expansion of tort liability thereof, see Patricia Danzon, *Tort Liability: A Minefield for Managed Care*, 26 J. LEGAL STUD. 491 (1997).

145. Typical are "more than two dozen bills" regulating HMOs introduced in the 1996 Maryland General Assembly critically referred to as "legislation by anecdote" or "legislation by body part." Terry M. Neal, *HMOs Feel the Heat in Maryland Fight Over Regulation*, WASH. POST, Mar. 1997, at B1. See also, David S. Hilzenrath, *Backlash Builds Over Managed Care*, WASH. POST, June 30, 1997, at A1; Milt Fruedenheim, *Pioneering State for Managed Care Fights for Change: California Thinks Again*, N.Y. TIMES, July 14, 1997, at

aged care, politicians may be unlikely to impose any sweeping reform to vitiate cost-containment policies; nor will employers likely tolerate it if politicians were so inclined.¹⁴⁶ Politicians may well focus on vote-winning strategies that regulate only the most objectionable cost-containment policies of HMOs.¹⁴⁷ The most notable example of legislative intervention is mandating forty-eight hour maternity stays instead of one-day "drive-through deliveries."¹⁴⁸ Recently, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has promulgated a more comprehensive "Patient's Bill of Rights."¹⁴⁹ In an effort to bolster flagging consumer confidence, even some HMOs have called for increased governmental regulation.¹⁵⁰

But politicians may well be unlikely to impose wholesale reforms upon the managed care industry.¹⁵¹ Not only may politicians be reluctant to curtail the cost-containment policies of HMOs because they are dependent upon managed care to control expenses in entitlement programs like Medicare and Medicaid,¹⁵² but also because the managed care industry—not to speak of the employers that utilize it—is extremely influential po-

A1. See also Passell, *supra* note 94, at 1 (arguing that "more government intervention than the insurance industry wants and less than the center-left had hoped for . . . [o]r, to put it another way: Hillary Lite" is likely to occur).

146. *Health Care Heavies*, *supra* note 42, at A20.

147. See, e.g., Hilzenrath, *supra* note 145, at A1 (detailing varying legislative efforts to curb perceived ills of managed care while preserving its fundamental character).

148. ANDERS, *supra* note 1, at 212.

149. See Laurie McGinley, *Broad Battle to End HMOs Limited Liability for Treatment—Coverage Denial Gains Steam*, WALL ST. J., Jan. 12, 1998, at A22. See also Laurie McGinley, *Clinton is Poised to Endorse Prescription By Panel on How to Improve Health Care*, WALL ST. J., Oct. 21, 1997, at B19. Political support for the proposal, however, is uncertain at best. See, e.g., Robert Pear, *Move Under Way to Try to Block Health Care Bills*, N.Y. TIMES, Nov. 4, 1997, at A1; see also Richard Arney, *Socialized Medicine on the Installment Plan*, WALL ST. J., Nov. 17, 1997, at A26. The political battles are obviously far from settled. For excellent coverage of the most recent developments in this regard, see generally articles written by Robert Pear and Kurt Eichenwald of the *New York Times*.

150. See Robert Pear, *3 Big Health Plans Urge National Standards*, N.Y. TIMES, Sept. 25, 1997, at A1.

151. But see Jonathan Rabinovitz, *Connecticut Votes to Restrict Denials under Managed Care*, N.Y. TIMES, May 22, 1997, at A1 (describing legislation that creates independent governmental review of HMOs' denials of coverage).

152. Burgess, *supra* note 45, at 291-92; see also Robert Pear, *Congress Weighs More Regulation on Managed Care*, N.Y. TIMES, Mar. 10, 1997, at A1 (discussing "Congress' love-hate relationship with managed care. Policy makers want to inject additional managed care into Medicare and Medicaid . . . [b]ut at the same time, they react to each new horror story by mandating new benefits"). See also Peter T. Kilbozn, *In Managed Care, "Consumer" Laws Benefit Doctors: Patients Seen as Losing*, N.Y. TIMES, Feb. 16, 1998, at A1 (indicating that laws mandating benefits are designed to preserve doctors' income and turf more than patients' needs).

litically.¹⁵³ In 1994, the insurance industry became the largest corporate donor to political campaigns.¹⁵⁴

Because no-fault compensation presents such substantial causation problems and because comprehensive political regulation of managed care seems politically, and arguably economically,¹⁵⁵ untenable, the tort system's efforts at compensation and internalization for negligent health care—even if inadequate—cannot be entirely abandoned. However, the tort system can be modified and its best features preserved for many malpractice claimants. A better system would strongly encourage settlements by health care providers, including HMOs, that fully and quickly compensate malpractice claimants for their actual economic losses, continue to deter negligent providers, and yet decrease the transaction costs of the current tort system. The next section of this Article details such a plan.

V. THE PROMISE OF "EARLY OFFERS"

Senator Mitch McConnell (R-KY) introduced the Legal Reform and Consumer Compensation Act of 1996¹⁵⁶ to replace a "mess-of-a-legal system" with "reforms that will ensure those who are injured get fairly and quickly compensated without resort to expensive and protracted litigation."¹⁵⁷ Similar provisions applicable to federally funded health care recipients were introduced a decade ago by Congressman Richard Gephardt (D-MO).¹⁵⁸ This proposed legislation would equip any civil defendant, including health care providers, and, in turn HMOs, with the option of offering a payment to a claimant within 120 days of an adverse medical occurrence covering all medical expenses, wage losses not paid by collateral sources, plus reasonable attorneys' fees.¹⁵⁹ It would, in other words, compensate eligible claimants for all of their net economic losses but not for noneconomic losses such as pain and suffering. The

153. ANDERS, *supra* note 1, at 210 (calling MCOs' "the best lobbyists in America" and noting that managed care companies pay lobbying firms to generate what appears to be "grassroots" opposition to legislation, but should more accurately be termed "astroturf lobbying").

154. *Id.* at 214.

155. *See supra* note 144 and accompanying text.

156. *See* S. 1861, 104th Cong. 2nd Sess. (1996).

157. 142 Cong. Rec. S6082, S6096, 104th Cong., 2nd Sess., June 11, 1996.

158. H.R. 5400, 98th Cong. (1984), and H.R. 3084, 99th Cong. (1985). For discussion, *see* W. Henson Moore & John S. Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, 49 L. & CONTEMP. PROBS. 117 (1986).

159. S. 1861, 104th Cong. 2nd Sess. (1996).

claimant would receive periodic payments as losses accrued, resulting in more accurate compensation than does the lump-sum payment of the present system¹⁶⁰ (though admittedly at the risk of increased malingering).¹⁶¹ In return for this "early offer," claimants would be required to surrender their tort remedies. Claimants could always reject such an offer and retain their ability to bring a tort suit, but would then be forced to prove, by a heightened burden of proof (clear and convincing evidence rather than the current preponderance of the evidence standard), a lower standard of care (intentional or wanton misconduct rather than mere negligence).¹⁶² Note, the defendant would always have the option of not making an early offer, in which case the claimant could resort to a standard tort action.

"Early offer" legislation represents a significant advantage over most reform measures that simply limit the claimant's potential recovery, typically by capping pain and suffering damages and contingent fees or by eliminating joint and several liability.¹⁶³ By addressing the over-compensation problem alone, these latter "reforms" unfairly favor only one party to the litigation¹⁶⁴ and improperly weaken the deterrent effect of tort law.¹⁶⁵ Although the early offer plan, by eliminating noneconomic damages and deducting for collateral sources, insulates potential defendants from exposure to tort's nearly limitless liability, it should retain the deterrent effect of the tort system by requiring prompt payment of all economic losses as a prerequisite for any relief from tort liability. Because claimants benefit from speedier compensation for economic losses without reduction for contingent attorneys' fees, early offers also address the under-compensation problem for claimants. The system provides both parties a quid pro quo¹⁶⁶ and limits reliance upon the cumbersome tort system to resolve only the most egregious cases of negligence or spurious

160. Periodic payments might well be accomplished by requiring that the defendant purchase an annuity on behalf of the claimant.

161. See generally Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 270 (1996).

162. 142 Cong. Rec. S6082, S6103, 104th Cong., 2nd Sess, June 11, 1996.

163. See, e.g., H.R. 956, 104th Cong., 2nd Sess. (1996) (limiting noneconomic damages to \$250,000 in any medical malpractice action).

164. Some "reforms" of this one-sided sort have even been declared unconstitutional. See, e.g., *Morris v. Savoy*, 576 N.E.2d 765 (Ohio 1991).

165. O'Connell, *supra* note 92, at 1309.

166. Arguably at least, such a quid pro quo is constitutionally required. See generally *New York Cent. R.R. v. White*, 243 U.S. 188 (1917); see also *Boyd v. Bulala*, 647 F.Supp. 781 (W.D. Va. 1986).

claims. It also allows both parties to escape the often daunting experience of an adversarial trial.

Critics may argue that an early offer system provides less deterrence than does the traditional tort liability system; that unless health care providers, including HMOs, are threatened with heavy tort judgments, they will not refrain from negligent practices. But importantly, claimants may elect to retain their tort action, preserving the threat of tort liability for what Anders cites as the most egregious instances of malpractice. Providers, therefore, face very real threats of potential liability under an early offer system, not to mention the obligation, when early offers are made, of guaranteeing their patients' net economic losses.

Additionally, early offer "defendants" may be prompted to make an early offer in more cases than they would currently lose in tort litigation. One defense attorney hypothesizes that he would make early offers to pay for economic losses in two hundred of the two hundred and fifty cases his office was currently defending, certainly higher than the number he would expect to lose in tort litigation.¹⁶⁷ While few early offers would likely equal the size of the tort system's more substantial verdicts, the increase in paid-claim frequency may offset the typically smaller judgments, and still impose very substantial costs on a defendant.

Several other deterrent factors warrant mention. Early offers would impose a swifter exaction on the HMO, chronologically linking injury and payment much more proximately than tort liability.¹⁶⁸ Additionally, the "early offer" legislation does not, by any means, eliminate reputational and other extra-judicial deterrents upon providers.¹⁶⁹ Because the early offer system compensates only for actual economic losses, some injured claimants (for example, the elderly, homemakers, the unemployed, or those with very ample collateral sources) may not be entitled to substantial payment. Thus, compensation for economic losses alone could underdeter the defendant in the event one of these individuals were injured. A simple solution would impose a minimum amount, or floor, of say \$250,000 to which all early offers covering serious injuries would be subject. Despite these substantial advantages, early offers, like any large-scale tort reform, is likely to engender substantial opposition from some distinct (and vocal) sectors. Most notably, the trial bar and consumer

167. O'CONNELL & KELLY, *supra* note 61, at 133.

168. *Id.* at 134.

169. Moore & O'Connell, *supra* note 68, at 1286 (*citing* the "professional pride, the opinion and review of one's peers, and the fear of adverse publicity" as effective deterrents). Indeed in this connection, *see supra* note 145 and accompanying text.

groups have historically opposed efforts to substantially reform our tort system.¹⁷⁰ But consumer groups might note that, although early offer awards will be lower than tort recoveries, because the claimant's transaction costs are reduced and attorney's fees are paid by the insurer on top of economic loss, the claimant may, in real dollars, recover above the level of the tort system,¹⁷¹ not to speak of doing so more promptly.

Providers' associations, notably the American Medical Association and the trade associations of managed care groups, may object to early offers because they fear the reputational ramification of any settlement offer.¹⁷² However, defendants retain complete discretion to extend the offer. If defendants desire to avoid any stigma associated with an early offer, they retain the ability to contest any tort claim. In this connection, though, an early offer settlement is intended to be less acrimonious than litigation, and should thus avoid much of the stigma associated with current medical malpractice claims.¹⁷³

VI. CONCLUSION

In *Health Against Wealth*, George Anders understandably, if overzealously, focuses on the injuries that HMOs' cost-containment policies may cause. Despite his animadversions, HMOs seem here to stay. Even so, public criticism of cost-containment policies coupled with the erosion of ERISA-provided immunity may well result in a dramatic increase in the incidence of malpractice claims against HMOs. And yet the current malpractice system is monumentally ineffective as both a compensatory and deterrent mechanism. At the same time, problems of causation seem to preclude no-fault compensation as an efficient malpractice alternative, while political and economic realities make wholesale regulation of HMOs equally unlikely.¹⁷⁴

170. See King, *supra* note 64, at 228 (describing the "fierce opposition of American negligence lawyers" to no-fault automobile insurance).

171. Randall, *supra* note 3, at 76.

172. The Health Care Improvement Act of 1996 (P.L. 99-660) established a National Practitioner Data Bank that records every malpractice judgment or settlement against a provider. See generally United States Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance, *National Practitioners' Data Bank: 1995 Annual Report*, Rockville, Maryland, 1996. Increasingly, consumer groups are demanding access to the data bank. See *States Increase Access to Physician Data*, HEALTH LEGIS. & REG. WEEKLY, Apr. 9, 1997.

173. Tancredi, *supra* note 71, at 279 (arguing that the same is true of some no-fault compensation reforms).

174. See BELL & O'CONNELL, *supra* note 91, at 253 n.3.

An early offer system, in contrast, reflects the wisdom of avoiding litigation costs, while at the same time deterring negligent health care providers—including HMOs—and encouraging immediate payment to injured patients.¹⁷⁵ It offers prompt compensation for actual economic losses to many more victims than does the tort system with dramatically lower transaction costs. Because of these clear advantages, the early offer system should be a marked improvement over our current tort system and represents a prudent reform in light of the likelihood of more numerous tort actions against HMOs and other managed care providers.¹⁷⁶

175. For a discussion of the early offer proposal as serving to correct the evils of false positives and false negatives, while still internalizing adverse results for health care, see Jeffrey O'Connell, *Two Tier Tort Law: Neo No-Fault & Quasi-Criminal Liability*, 27 WAKE FOREST L. REV. 871 (1992).

176. A thorough review of all major proposals to deal with medical malpractice litigation concludes that only the early offer approach offers a realistic hope for prompt cure to the major ills of such litigation. Tan, *supra* note 59, at 273-74. See also Havighurst, *supra* note 22, at 645 (inviting "alternatives to . . . tort law that would represent major improvements in the welfare of everyone concerned—everyone, that is, except trial lawyers and malpractice insurers").